The State of Delaware

GHIP FY18 Savings Opportunities

February 6, 2017

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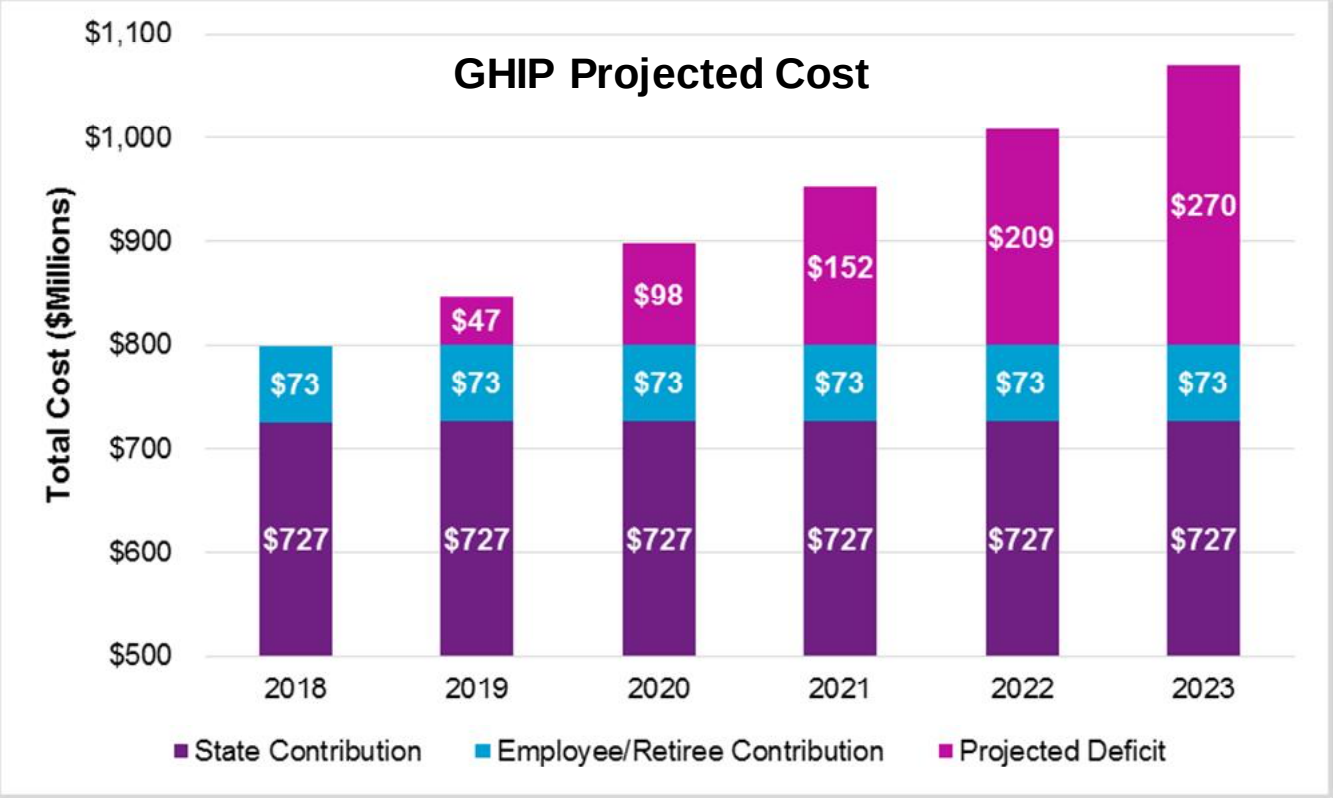
Long term health care cost projections

Long-term cost projections of the Group Health Insurance Plan, at intermediate trend value of 6%, with no increase in state or employee/retiree contributions factored in for 2018 forward (assuming no program changes)



Every 1% of GHIP budget growth (trend) increases the FY18 projected budget by an additional $8.0M. This would require an additional $7.3M in State Contributions ($5.0M from the General Fund), and an additional $0.7M in employee/pensioner contributions.

Note: FY18 budget projections based on updated claims experience through December 2016 and revised ESI contract savings estimates. FY19 and beyond costs projected assuming 6% annual health care trend and no further program changes.

Governor Markell's proposed budget
Savings estimates

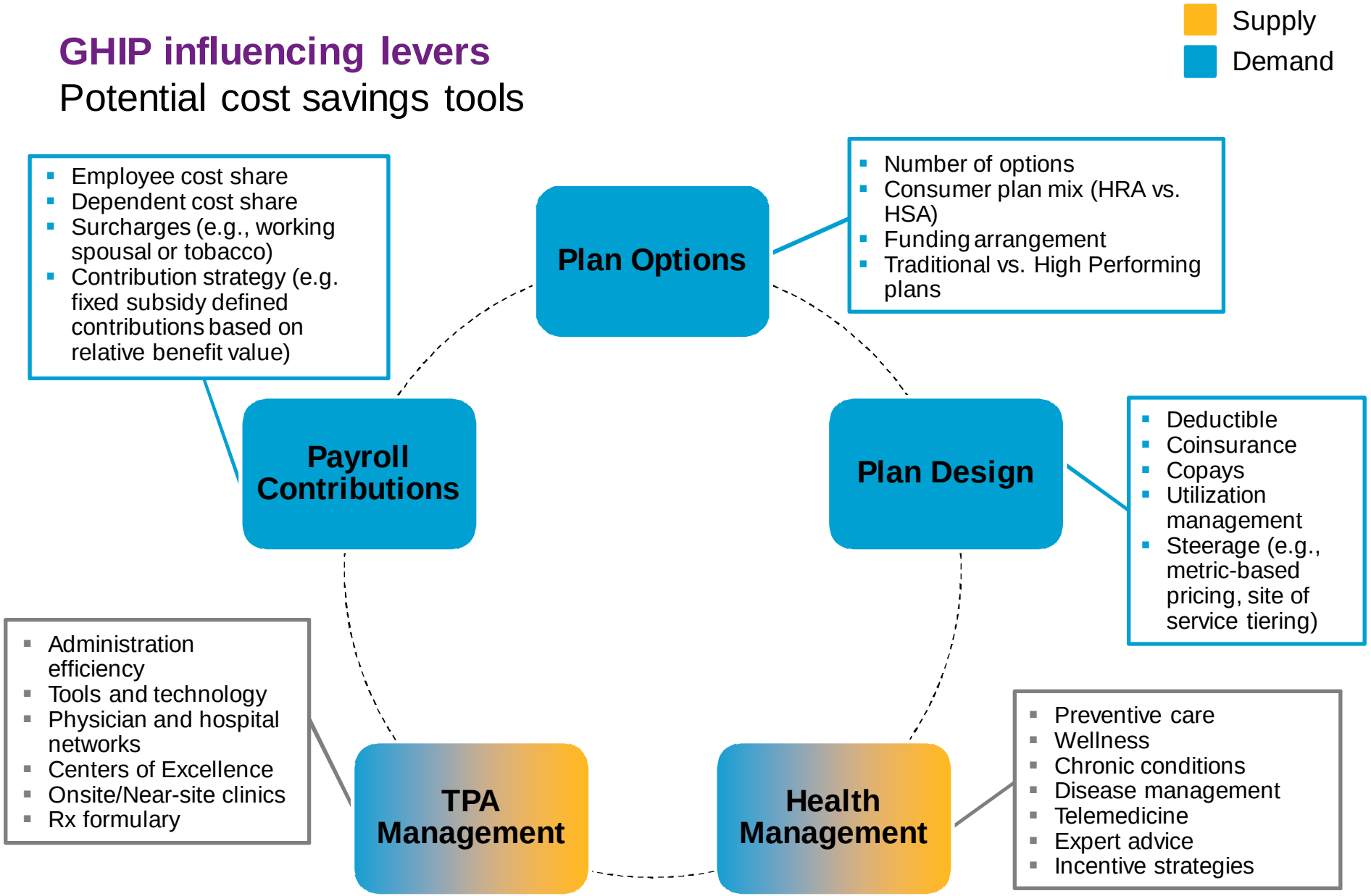
- Within Governor Markell's proposed budget, the general fund savings total $23.968M
  - The budget outlines changes that would be effective July 1, 2017
- Outlined below is the breakdown of these savings:

Element	Description	FY18 Savings[1]
Special Medicfill plan Modification	Elimination of contribution inequity for members who currently pay no monthly premium for the special Medicfill plan. This change would require these pensioners to pay 5% of the special Medicfill plan.	$2.04M
Elimination of Double State Share	Employees and retirees who are married would no longer be eligible for reduced contributions. These members would be treated the same as other GHIP members.	$3.50M
Plan Design Modifications to Current Plans	Implementation of deductibles for the PPO and HMO plans and increase in deductibles for FSB and CDH plans	$15.164M
Health Savings Account Adoption for 1/1/2018	Adoption of a new health plan with Health Savings Accounts for participants with less than 10 years of service (hired on or after 1/1/2008)	$3.264M[2]
	Total Savings	**$23.968M**

[1] Savings reflect approx. portion of GHIP budget attributable to General Fund for the period 7/1/2017 – 6/30/2018
[2] Savings are incremental for last 6 months of FY18, representing additional savings beyond plan design changes implemented for current plans

GHIP influencing levers

Potential cost savings tools



GHIP short and long term cost control

Potential modifications for FY2018

Category	Changes approved by the SEBC	Changes for further review with the SEBC	
		Legislative action not required	Legislative action required
Plan Options	4 Main Plan Options - Aetna HMO with AIM - Aetna CDH Gold w/ HRA - Highmark PPO - Highmark First State Basic (FSB) 2 Other Plan Options - Highmark POS (closed group) - Highmark Medicfill • Streamline plan offerings by discontinuing the Highmark HMO and the Highmark CDH Gold plans (i.e., one vendor per plan) • Increase decision support through education and marketing of health plan options to employees/retirees • Educate plan participants on the tools and technology available through each vendor and plan, and encourage utilization of those resources	None	• Require employees/ pensioners to make an enrollment election during Open Enrollment (i.e., "active enrollment") or they will be automatically enrolled by default into a medical plan selected by the State
Plan Design	None	• Modify plan designs to encourage smarter consumption of health care and steerage to value-based care delivery models, i.e., add deductibles to the PPO and HMO plans, increase current CDH Gold and FSB deductibles • Steer plan participants to centers of excellence using plan design incentives	None

GHIP short and long term cost control

Potential modifications for FY2018

Category	Changes approved by the SEBC	Changes for further review with the SEBC	
		Legislative action not required	Legislative action required
Health Management	None	• Adopt enhanced clinical management program with Highmark • Adopt incentives to drive engagement in health management programs and preventive care	None
TPA/Provider Management	• Reduce administrative fees through Medical TPA RFP • Select vendor partners that offer value-based care models as embedded or standalone components of medical provider networks • Work with both TPAs to continue analyzing data on the performance of the medical plan (i.e., operational, utilization, clinical, financial data) to measure results against baseline and adjust future strategy based on emerging data	• Adopt on-site clinic to improve access to care and steer plan participants to lower cost, high performing providers (note: pending results of onsite clinic RFI, to be released in Q3 FY17)	None
Payroll Contributions	None	None	• Eliminate contribution inequity for the Medicfill plan • Eliminate double state share for married employees and retirees • Consider taking an incremental approach to adjusting medical plan price tags for employees/ pensioners so that member cost sharing is based on the actuarial value of the plans and is aligned with the State's enrollment goals

GHIP short and long term cost control

Potential modifications for FY2019

Category	Changes for further review with the SEBC	
	Legislative action not required	Legislative action required
Plan Options	3 Main Plan Options - Aetna HMO with ACO - Aetna CDH Gold w/ HRA - HDHP w/ HSA (vendor TBD) 2 Other Plan Options - Highmark POS (closed group) - Highmark Medicfill • Introduce new plan option: HDHP w/ HSA	• Eliminate the Highmark FSB and PPO plans • Continue requirement that employees/pensioners must make an enrollment election during Open Enrollment (i.e., "active enrollment") or be automatically enrolled by default into a medical plan selected by the State
Plan Design	• Apply deductible/coinsurance to the majority of services, rather than a copay • Provide additional incentives for steerage to high performing providers (physicians, centers of excellence, etc.) through plan design (e.g., reduced cost sharing for using these providers, travel and lodging benefits for use of centers of excellence, etc.) and/or through additional State-funded contributions to plan participant HRAs/HSAs • Continue communications encouraging utilization of tools and technology (i.e., transparency tools) and the importance of using high performing providers • Explore and implement medical TPA programs that support utilization management, such as tiered pricing for lab services and high cost radiology, where necessary	None

GHIP short and long term cost control

Potential modifications for FY2019

Category	Changes for further review with the SEBC	
	Legislative action not required	Legislative action required
Health Management	• Adopt additional incentives to drive engagement in health management programs and preventive care • Launch communications focused on educating plan participants on: o Preventive care benefits, lifestyle management programs (e.g., weight management, tobacco cessation) and disease management programs o Other provider quality tools from CMS and other reputable clinical sources such as Health Grades and Leapfrog • Expand FY17 consumerism course content and distribution methods to continue promoting health and wellness	None
TPA/Provider Management	• Continue working with both TPAs to analyze data on medical plan performance to measure results and inform future strategy	None
Payroll Contributions	None	• Consider greater contribution differentiation among plan options to align with plan value • Consider surcharges for tobacco use • Consider and analyze options that decrease state subsidy on coverage of spouses and dependents

Goals:
- ■ Addition of at least net 1 VBCD model by end of FY2018
- ○ Reduction of gross GHIP trend by 2% by end of FY2020
- ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

Savings opportunities

Identified elements from the GHIP strategic framework (finalized December, 2016)

- The State Employee Benefits Committee (SEBC) agreed upon a long-term strategic plan for the Group Health Insurance Program (GHIP) with the aim of reduced costs and improved consumer activation
  - While many of these programs may not necessarily be effective 7/1/2017, savings shown below represent adoption during FY18 but do not capture future opportunities for additional savings beyond FY18 (i.e., trend reduction in FY19 and later)
  - Outlined below are selected areas of potential cost savings from the strategic framework:

	Element	GHIP Goals	Description	FY18 Savings[1]
Already Planned for FY2018	Reduction of Administrative Fees through Medical TPA RFP[2]	○	The Medical TPA RFP resulted in reduced administrative fees for all plans and elimination of two plan options (Highmark HMO and Highmark CDH Gold)	$1.0M
	Addition of Value-Based Care Models[4]	■○▲	Participation in vendor value-based care models, including Aetna (AIM) and Highmark (True Performance) will yield savings through risk sharing arrangements and better management of populations	$1.1M
	Improved consumerism as a result of decision support[5]	▲○	Increasing decision support through education and marketing of health plan options may yield savings by making State employees better health care consumers	$3.0M
	Adoption of On-site Clinic[3]	■○	Adoption of an on-site clinic for the State may yield savings through improved access to care and steerage to lower cost, high performing providers	$1.0M
	Special Medicfill plan Modification[6]	○	Elimination of contribution inequity for members who currently pay no monthly premium for the special Medicfill plan. This change would require these pensioners to pay 5% of the special Medicfill plan.	$2.0M
	Elimination of Double State Share[6]	○	Employees and retirees who are married would no longer be eligible for reduced contributions. These members would be treated the same as other GHIP members.	$3.5M
	Plan Design Modifications	▲○	While this has not been explored in great detail with the SEBC, there is opportunity to reduce the number of plan options/modify plan designs to encourage smarter consumption of health care and steerage to VBC. Savings modeled here assume 7/1/17 implementation of the following design changes: **Option 1** Add $250 single / $500 family deductible to the PPO plan only **Option 2** Add $250 single / $500 family deductible to the PPO and HMO plans Increase the current CDH Gold and FSB deductibles by $250 single / $500 family	$4.7M - $8.3M
	Enhanced Highmark Clinical Management Program[7]	○	Adoption of enhanced program for clinical management *(more detail to be provided at next SEBC meeting)*	$3.0M - $6.0M
			Total Savings **Total Savings (Excluding Activities Already Planned for FY18)**	**$19.3M – $25.9M** **$14.2M - $20.8M**

[1] Savings reflect approx. portion of GHIP budget attributable to General Fund for the period 7/1/2017 – 6/30/2018
[2] Administrative Fees for FY18 exclude additional fees for value-based care models (AIM and True Performance). Savings reflects migration from Highmark HMO and Highmark CDH to other plan options.
[3] On-site clinic savings are estimated. Savings will be further vetted through RFI process. Figure assumes 10k employees eligible for access to single clinic ($2.0m assumed operating expenses. Assumed run-rate ROI is 1.5:1)
[4] Savings net of risk sharing payments, Care Link and True Performance program fees.
[5] Decision support savings are a high-level estimate, assuming 1% reduction in medical claim costs for Active population
[6] Denotes savings opportunities that appear in both Governor Markell's proposed budget as well as the GHIP strategic plan
[7] Savings estimate based on Highmark FY18 plans only. Excludes savings for enhanced clinical management through Aetna AIM. Savings net of administrative fees.

Default enrollment option for FY2018

- Highmark HMO and Highmark CDH Gold plans will be terminated effective 7/1/2017
  - High likelihood that some subscribers in these plans will not select a new plan during FY2018 Open Enrollment
- The State must determine the "default" option for those subscribers who do not select a new plan
- Budget epilogue language prevents default enrollment for enrollees in plans that will remain in effect in FY2018

FY17 Current Plan	FY18 Default Plan Options				
	Option 1: Similar Plan	**Option 2: Lowest AV plan**	**Option 3: PPO Plan**	**Option 4: Aetna CDH Gold**	**Option 5: Aetna HMO**
Highmark HMO *(AV: 0.970)*	**Aetna HMO** *(AV: 0.970)*	**Highmark First State Basic** *(AV: 0.907)*	**Highmark PPO** *(AV: 0.967)*	**Aetna CDH Gold** *(AV: 0.830)*	**Aetna HMO** *(AV: 0.970)*
Employee cost for:	*Increase / (Decrease) in employee cost:*				
Single: $47 / month Family: $125 / month	Single: $0 / month Family: ($1) / month	Single: ($19) / month Family: ($53) / month	Single: $58 / month Family: $148 / month	Single: ($11) / month Family: ($30) / month	Single: $0 / month Family: ($1) / month
Highmark CDH Gold *(AV: 0.830)*	**Aetna CDH Gold** *(AV: 0.830)*	**Highmark First State Basic** *(AV: 0.907)*	**Highmark PPO** *(AV: 0.967)*	**Aetna CDH Gold** *(AV: 0.830)*	**Aetna HMO** *(AV: 0.970)*
Employee cost for:	*Increase / (Decrease) in employee cost:*				
Single: $36 / month Family: $95 / month	Single: $0 / month Family: $0 / month	Single: ($8) / month Family: ($23) / month	Single: $69 / month Family: $178 / month	Single: $0 / month Family: $0 / month	Single: $11 / month Family: $29 / month

AV = Actuarial value; reflects current FY2017 medical plan designs.
Employee costs and AVs displayed above for both FY2017 and FY2018 reflect current FY2017 medical plan price tags and benefit designs, as the FY2018 price tags and designs have not yet been finalized.
Both Highmark and Aetna CDH Gold plan AVs are shown without the State-funded HRA seed (worth +0.133 points of AV).

Default enrollment considerations

FY18 Default Plan Options	FY17 Current Plan			
	Highmark HMO		Highmark CDH Gold	
	Pros	Cons	Pros	Cons
Option 1: Similar Plan (Remain in current plan under Aetna)	• Same plan design (except gatekeeper); little employee disruption in understanding plan provisions • More managed plan costs (need a referral to go out-of-network under Aetna) • Little to no increase in EE contributions	• Slight increase in GHIP net contribution	• Same plan design; little employee disruption in understanding plan provisions • Continue consumer directed plan management • No change in EE/ER contributions	
Option 2: Lowest AV Plan (Highmark First State Basic)	• Lower cost to employees • Decrease in GHIP net contribution	• Decrease in plan value may mean higher OOP costs for employees	• Lower cost to employees • Decrease in GHIP net contribution	• Decrease in plan value (after accounting for HRA seed funding) may mean higher OOP costs for employees • Loss of ER HRA funding
Option 3: PPO Plan (Highmark Comprehensive PPO)	• EE choice of in-network vs. out-of-network providers	• Increase in EE contributions • Least managed plan costs	• First dollar coverage	• Increase in EE contributions • Least managed plan • Loss of ER HRA funding
Option 4: Aetna CDH Gold	• Consumer directed plan management • Lower cost to employees	• Education needed for EEs to understand consumer driven health plans • Increase in GHIP net contribution	• Same plan design; little employee disruption in understanding plan provisions • Continue consumer directed plan management • No change in EE/ER contributions	
Option 5: Aetna HMO	• Same plan design (except gatekeeper); little employee disruption in understanding plan provisions • More managed plan costs (need a referral to go out-of-network under Aetna) • Little to no increase in EE contributions	• Slight increase in GHIP net contribution	• More managed plan costs	• EE Disruption due to mandatory out-of-network provider referrals

Default enrollment recommendation

Option #1: Default enrollees to similar plans
(Highmark HMO and CDH to Aetna HMO and CDH, respectively)

- Cost neutral to employees and GHIP
  - CDH enrollees continue to receive employer HRA funding
- **Aligns with strategy** to maximize plan enrollment in value-based and consumer-driven plans (plans will help to better manage future plan costs)
  - HMO enrollees participate in Aetna's AIM model
  - CDH enrollees continue in a consumer driven health plan
- Enrollees already understand current plan provisions